CHAPTER 9

DENIAL, REDUCTION, SUSPENSION OR TERMINATION OF WAIVER SERVICES

Any time a waiver service is denied, reduced, suspended or terminated, the participant/legal guardian must be given written notice to include the details regarding the denial, reduction, suspension or termination of service(s) and the allowance for appeal/reconsideration. Additionally, there is a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before proceeding with a reduction, suspension or termination (when applicable).

It is a Federal requirement for the State to provide an opportunity for a fair hearing. According to Medicaid policy, the State (in this case, the Service Coordination Provider) must send written notice at least ten (10) calendar days before the date of action. The following do not require a ten (10) calendar day notice before proceeding with the action:

- Denial of waiver service(s), including requests for units beyond established limits
- Client-requested reduction
- Termination due to loss of Medicaid eligibility
- Voluntary withdrawal
- Termination due to death
- Termination due to move out of state
- Termination due to admission to an ICF/MR/Nursing Facility or Jail

If the participant/legal guardian requests a hearing before the date of action, the State may not terminate, suspend or reduce services until a decision is rendered after the hearing. If the State's action is sustained by the hearing decision, the State may institute recovery procedures against the participant/legal guardian to recoup the cost of any services furnished to the participant, to the extent that they were furnished solely by reason of the appeal/reconsideration.

Denials: If the participant/legal guardian requests a waiver service and is denied (either at the local or state level), the Service Coordinator or Early Interventionist is responsible for completing the Notice of Denial of Service (MR/RD Form 16-A) within two (2) working days of notification that the service request is denied. The service(s) that is/are denied should be indicated on the form along with the reason(s) and any comments supporting those reasons. The original Notice of Denial of Services (MR/RD Form 16-A) is sent to the participant/legal guardian along with the appeals process included/attached. A copy should be placed in the participant's file.

Terminations: If a waiver service is scheduled to be terminated, the Service Coordinator/Early Interventionist must complete the Notice of Termination of Service (MR/RD Form 16-B). The service(s) scheduled to be terminated should be indicated on the form along with the reason(s) and any comments

supporting those reasons. The effective date for termination will be at least ten (10) calendar days from the date that the form is completed and sent to the participant/legal guardian (exceptions previously noted apply), which gives the participant notice prior to termination of the service and the opportunity to request reconsideration of/appeal the decision prior to termination. If the participant requests reconsideration or appeals within 10 calendar days of the notification, then the participant may choose to continue to receive the services uninterrupted while awaiting the outcome of the reconsideration/appeal. If, however, the decision is upheld upon reconsideration/appeal, then the participant will be liable for payment of those services. Although the participant has a total of thirty (30) calendar days to request reconsideration of/appeal the decision, the service will be terminated if the reconsideration is not requested or the decision appealed within ten (10) calendar days. The original Notice of Termination of Service (MR/RD Form 16-B) is sent to the provider of the service. A copy, with the appeals process included/attached, is sent to the participant/legal guardian, and another copy should be placed in the participant's file.

Note: If the participant requests reconsideration or appeals within 10 calendar days of the notice of termination and chooses to continue to receive services while awaiting the outcome of the reconsideration/appeal, the Service Coordinator/Early Interventionist must contact the provider of service and ensure that the service continues uninterrupted.

Suspensions: When enrolled in the MR/RD Waiver, there may be circumstances where a participant's service(s) may need to be suspended, but not terminated. One such example is when a participant is admitted to a hospital. In these instances, all waiver services must be suspended. Many participants and their providers of Residential Habilitation have made arrangements to have prescribed drugs and Assistive Technology supplies delivered directly to the residence on a regular schedule. These arrangements must cease while the participant is hospitalized.

If a waiver service is scheduled to be suspended, the Service Coordinator/Early Interventionist must complete the Notice of Suspension of Service (MR/RD Form 16-C). The service(s) scheduled to be suspended should be indicated on the form along with the reason(s) and any comments supporting those reasons. The effective date for suspension will be at least ten (10) calendar days from the date that the form is completed and sent to the participant/legal guardian (exceptions previously noted apply), which gives the participant notice prior to suspension of the service and the opportunity to request reconsideration of/appeal the decision prior to suspension. If the participant has been admitted to a hospital, then ten (10) calendar days notice is not required. If the participant requests reconsideration or appeals within 10 calendar days of the notification, then the participant may choose to continue to receive the services uninterrupted while awaiting the outcome of the reconsideration/appeal. If, however, the decision is upheld upon reconsideration/appeal, then the participant will be liable for payment of those services. Although the participant has a total of thirty (30) calendar days to request reconsideration of/appeal the decision, the service will be suspended if the reconsideration is not requested or the decision appealed within ten (10) calendar days. The original Notice of Suspension of Service (MR/RD Form 16-C) is sent to the provider of the service. A copy, with the appeals process included/attached, is sent to the participant/legal guardian, and another copy should be placed in the participant's file.

Once the participant is ready to resume the service(s), the Service Coordinator/Early Interventionist must submit a new authorization form to the designated provider(s).

If the Level of Care certification or the Support Plan exceeds three hundred sixty five (365) days, waiver services must be suspended until a current Level of Care certification or Support Plan is completed, at which time a new authorization form must be completed.

Note: If the participant requests reconsideration or appeals within 10 calendar days of the notice of suspension and chooses to continue to receive services while awaiting the outcome of the reconsideration/appeal, the

Service Coordinator/Early Interventionist must contact the provider of service and ensure that the service continues uninterrupted.

Reductions: If a waiver service is scheduled to be reduced, the Service Coordinator/Early Interventionist must complete the Notice of Reduction of Service (MR/RD Form 16-D). The service(s) scheduled to be reduced should be indicated on the form along with the reason(s) and any comments supporting those reasons. The effective date for reduction will be at least ten (10) calendar days from the date that the form is completed and sent to the participant/legal guardian (exceptions previously noted apply), which gives the participant notice prior to reduction of the service and the opportunity to request reconsideration of/appeal the decision prior to termination. If the participant requests reconsideration or appeals within 10 calendar days of the notification, then the participant may choose to continue to receive the services uninterrupted while awaiting the outcome of the reconsideration/appeal. If, however, the decision is upheld upon reconsideration/appeal, then the participant will be liable for payment of those services. Although the participant has a total of thirty (30) calendar days to request reconsideration of/appeal the decision, the service will be reduced if the reconsideration is not requested or the decision appealed within ten (10) calendar days. The original Notice of Reduction of Service (MR/RD Form 16-D) is sent to the provider of the service. A copy, with the appeals process included/attached, is sent to the participant/legal guardian, and another copy should be placed in the participant's file. The Service Coordinator/Early Interventionist must also complete a new authorization, reflecting the reduced units of service, and send the original to the provider. Copies of the new authorization should also be sent to the participant/legal guardian and placed in the participant's file.

Note: If the participant requests reconsideration or appeals within 10 calendar days of the notice of reduction and chooses to continue to receive services in the authorized amount while awaiting the outcome of the reconsideration/appeal, the Service Coordinator/Early Interventionist must contact the provider of service and ensure that the service continues uninterrupted.

If a request for reconsideration or a notice of appeal to DHHS is received by SCDDSN Central Office, the Service Coordinator/Early Interventionist will be promptly notified and instructed on how to proceed.

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

NOTICE OF DENIAL OF SERVICE

To: _____ (Please check one: ☐ Participant ☐ Legal Guardian)

Address: _____
_____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED THAT THE REQUEST FOR THE FOLLOWING SERVICE(S) FOR THE PERSON NAMED ABOVE HAS BEEN DENIED. EXPLANATION OF APPEAL RIGHTS IS ATTACHED.

- ☐ Adult Attendant Care Services
- ☐ Adult Day Health Care
- ☐ Adult Day Health Care Nursing
- ☐ Adult Day Health Care Transportation
- ☐ Adult Companion Services
- ☐ Adult Dental Services
- ☐ Adult Vision Services
- ☐ Audiology Services
- ☐ Behavior Support Services
- ☐ Career Preparation Services
- ☐ Community Services
- ☐ Day Activity
- ☐ Employment Services
- ☐ Environmental Modifications
- ☐ Nursing Services
- ☐ Personal Care Services
- ☐ Personal Emergency Response System (PERS)
- ☐ Prescribed Drugs
- ☐ Private Vehicle Modifications
- ☐ Psychological Services
- ☐ Residential Habilitation
- ☐ Respite Care
- ☐ Specialized Medical Equipment, Supplies and Assistive Technology (* listed below)
- ☐ Speech-Language Pathology
- ☐ Support Center Services

* Assistive Tech: _____

Reason:

- ☐ Need(s) not justified
- ☐ Service(s) available through State Plan Medicaid
- ☐ Exceeds service limits
- ☐ Other: _____

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____

Phone # _____

_____ _____
Signature of Service Coordinator Date

Original: Participant/legal guardian / Copy: File

MR/RD Form 16-A (Revised 12/09) **APPEALS PROCESS MUST BE ATTACHED**

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

NOTICE OF TERMINATION OF SERVICE

To: _____

Address: _____
_____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE(S) TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF MAY BE BILLED.

- ☐ Adult Attendant Care Services
- ☐ Adult Day Health Care
- ☐ Adult Day Health Care Nursing
- ☐ Adult Day Health Care Transportation
- ☐ Adult Companion Services
- ☐ Adult Dental Services
- ☐ Adult Vision Services
- ☐ Audiology Services
- ☐ Behavior Support Services
- ☐ Career Preparation Services
- ☐ Community Services
- ☐ Day Activity
- ☐ Employment Services
- ☐ Environmental Modifications
- ☐ Nursing Services
- ☐ Personal Care Services
- ☐ Personal Emergency Response System (PERS)
- ☐ Prescribed Drugs
- ☐ Private Vehicle Modifications
- ☐ Psychological Services
- ☐ Residential Habilitation
- ☐ Respite Care
- ☐ Specialized Medical Equipment, Supplies and Assistive Technology
- ☐ Speech-Language Pathology
- ☐ Support Center Services

Reason:

- ☐ Change in need; no longer justifies original request
- ☐ No longer meets ICF/MR Level of Care
- ☐ Change in provider availability
- ☐ Entered an ICF/MR
- ☐ Voluntary withdrawal
- ☐ Death (do not send a copy to the family)
- ☐ Medical condition has improved
- ☐ Participant/legal guardian requested
- ☐ Medicaid ineligible
- ☐ Participant moved out of state
- ☐ Facility stay exceeded 30 consecutive days
- ☐ Other (explain in comments below)

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____

Phone # _____

_____ _____
Signature of Service Coordinator Date

Original: Provider / Copy: Participant/legal guardian, File

MR/RD Form 16-B (Revised 12/09) **APPEALS PROCESS MUST BE ATTACHED**

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

NOTICE OF SUSPENSION OF SERVICE

To: _____

Address: _____
_____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE(S) TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF MAY BE BILLED.

- ☐ Adult Attendant Care Services
- ☐ Adult Day Health Care
- ☐ Adult Day Health Care Nursing
- ☐ Adult Day Health Care Transportation
- ☐ Adult Companion Services
- ☐ Adult Dental Services
- ☐ Adult Vision Services
- ☐ Audiology Services
- ☐ Behavior Support Services
- ☐ Career Preparation Services
- ☐ Community Services
- ☐ Day Activity
- ☐ Employment Services
- ☐ Environmental Modifications
- ☐ Nursing Services
- ☐ Personal Care Services
- ☐ Personal Emergency Response System (PERS)
- ☐ Prescribed Drugs
- ☐ Private Vehicle Modifications
- ☐ Psychological Services
- ☐ Residential Habilitation
- ☐ Respite Care
- ☐ Specialized Medical Equipment, Supplies and Assistive Technology
- ☐ Speech-Language Pathology
- ☐ Support Center Services

Reason:

- ☐ Medical condition has improved
- ☐ No longer meets ICF/MR Level of Care
- ☐ Change in provider availability
- ☐ Entered hospital/rehab (less than 30 calendar days)
- ☐ Entered nursing facility (less than 30 calendar days)
- ☐ Other: _____

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____

Phone # _____

_____ _____
Signature of Service Coordinator Date

Original: Provider / Copy: Participant/legal guardian, File

MR/RD Form 16-C (Revised 12/09) **APPEALS PROCESS MUST BE ATTACHED**

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

NOTICE OF REDUCTION OF SERVICE

To: _____

Address: _____
_____

Participant's Name: _____ DOB: _____ Medicaid #: _____

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE(S) TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF MAY BE BILLED.

- ☐ Adult Attendant Care Services
- ☐ Adult Day Health Care
- ☐ Adult Day Health Care Nursing
- ☐ Adult Day Health Care Transportation
- ☐ Adult Companion Services
- ☐ Adult Dental Services
- ☐ Adult Vision Services
- ☐ Audiology Services
- ☐ Behavior Support Services
- ☐ Career Preparation Services
- ☐ Community Services
- ☐ Day Activity
- ☐ Employment Services
- ☐ Environmental Modifications
- ☐ Nursing Services
- ☐ Personal Care Services
- ☐ Personal Emergency Response System (PERS)
- ☐ Prescribed Drugs
- ☐ Private Vehicle Modifications
- ☐ Psychological Services
- ☐ Residential Habilitation
- ☐ Respite Care
- ☐ Specialized Medical Equipment, Supplies and Assistive Technology
- ☐ Speech-Language Pathology
- ☐ Support Center Services

Reason:

- ☐ Change in need; no longer justifies original request
- ☐ No longer meets ICF/MR Level of Care
- ☐ Other: _____
- ☐ Medical condition has improved
- ☐ Participant/legal guardian requested

Comments (required): _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____

Phone # _____

_____ _____
Signature of Service Coordinator Date

Original: Provider / Copy: Participant/legal guardian, File

MR/RD Form 16-D (Revised 12/09) **APPEALS PROCESS MUST BE ATTACHED**

SCDDSN RECONSIDERATION AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disabilities (MR/RD) Waiver, the Pervasive Developmental Disorder (PDD), the Community Supports Waiver (CSW) and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision must be sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. **The SCDDSN reconsideration process must be completed in its entirety before appealing to the South Carolina Department of Health and Human Services (SCDHHS).**

A formal request for reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the participant, the representative or the person assisting the participant in filing the request. If necessary, staff will assist the participant in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the participant/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the participant/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the participant/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the participant/representative fully completes the above reconsideration process and is dissatisfied with the results, the participant/representative has the right to appeal to the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The participant/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The participant/representative must attach a copy of the written reconsideration notification received from the SCDDSN regarding the specific matter that is the subject of the appeal. In the appeal request, the participant/representative must clearly state with specificity, which issue(s) the participant/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The participant/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.